



## **MONTANA STATE HOSPITAL POLICY AND PROCEDURE**

### **USE OF SECLUSION AND RESTRAINT**

**Effective Date:** August 1, 2006

**Policy #:** TX-16

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#### **I. PURPOSE:**

- A. To establish hospital policy and procedures governing the use of seclusion and restraint procedures to be used only when a patient is at risk of harming him/herself or others, and no other less restrictive intervention is possible.
- B. To ensure seclusion and restraint procedures are used in accordance with state law and federal regulations.
- C. To ensure that when seclusion or restraint procedures are used, staff respect the patient and treat individuals with dignity to the greatest extent possible, and protect the rights of all individuals involved.

#### **II. POLICY:**

- A. Montana State Hospital (MSH) is committed to a violence-free environment. We must continually reinforce to all people, that violent acts and threats are not acceptable behaviors, and we must provide an appropriate response when these behaviors occur.
- B. Montana State Hospital is also committed to reducing the use seclusion and restraint and perhaps one-day eliminating the use of these procedures altogether. We also recognize that use of restraint and seclusion is not necessarily an appropriate response to violent and threatening behaviors and may only be used when there is an imminent risk of significant violence or self-injurious behavior.
- C. It is the policy of the Montana State Hospital to provide care and treatment in a manner that is the least restrictive of patient movement and freedom. Seclusion and restraint are emergency procedures used only to prevent people from harming others or one self.
- D. Seclusion and restraint are not treatment and may not be implemented as a consequence in response to a previously occurring behavior.
- E. Seclusion and Restraint procedures may be used only when clinically justified in accordance with a physician's order and used only when no other less restrictive intervention is possible. Seclusion and Restraint procedures must be ended at the earliest possible time. Per Needed Orders (PRN) are not used in regard to Seclusion and/or Restraint Intervention.

- F. Patients, and where appropriate, guardians and family/significant others are engaged in education strategies to prevent violence from occurring and reduce the use of seclusion and restraint.

### III. DEFINITIONS:

- A. Seclusion is involuntary confinement of a patient in a room or an area from which the person is prevented from leaving.
- B. Restraint is the use of a device *or physical technique* to restrict a patient's ability to react physically by temporarily limiting his/her freedom of body and limb movement. Only those devices approved by MSH administration will be used to physically restrain a patient. See Attachment A for a list of restraints approved for use at MSH.

- C. Chemical Restraint is not approved for use at MSH.

Chemical Restraint – A drug used as a restraint is a medication used to control behavior or to restrict the patient’s freedom of movement and is not a standard treatment for the patient’s medical or psychiatric condition.

- D. Emergency Transport Restraints Wrist and ankle restraints or the transport blanket may be used for brief periods to safely transport a patient in an emergency situation. Examples of this use include use of wrist and/or ankle restraints to transport a patient on unauthorized leave safely back to their treatment unit, or use of the transport blanket to transport an acting-out patient to a safe location within a treatment unit. Use of emergency transport restraints require an order and face-to-face evaluation by a physician/Licensed Independent Practitioner (LIP) within one hour, and with documentation and review required just as with all other use of restraint procedures.
- E. Clinical assessment for seclusion and restraint -- an assessment in which a Licensed Independent Practitioner substantiates through documentation in the medical record that the reason for a patient being placed in seclusion/restraint is in order to prevent harm to self or others.
- F. Criteria/clinical justification for seclusion or restraint – To prevent the patient from injuring themselves or others when less restrictive interventions are inadequate to prevent the behavior.
- G. Emergency – An emergency is a situation in which action is necessary to prevent immediate injury to others, and/or to prevent injury to self.
- H. Trained staff: includes Psychiatrist / Licensed Independent Practitioners (LIP), licensed nursing staff and direct care staff who have been trained in de-escalation techniques, and safe management of seclusion and restraints.

- I. Certified Mental Health Professional Person: A person meeting Department of Public Health and Human Services requirements to fulfill duties and obligations allowed under Administrative Rules of Montana.
- IV. **RESPONSIBILITIES:** Staff who have received facility approved training in de-escalation and safe management of seclusion and restraint may participate in secluding or physically restraining patients.
- A. All MSH employees are responsible for supporting the commitment of MSH to reduce and or eliminate seclusion and restraint use and violence in general by utilizing less restrictive measures such as the de-escalation techniques listed in Attachment C.
- B. Staff Development shall conduct regular training for all staff involved in the use of seclusion or restraints and alternative methods of de-escalation and interventions.
- C. The Seclusion and Restraint Committee will perform an administrative review of seclusion and restraint.
- D. Seclusion or restraint shall be utilized only in cases of emergency and imminent danger when other less restrictive methods have failed. Alternative approaches must be attempted prior to the use of seclusion/restraint.
- E. Staff shall make all efforts to preserve the privacy, safety, human dignity, and the physical and emotional comfort of the patient at all times.
- F. Staff shall ensure that the duration of the seclusion or restraint procedure be the shortest time possible to reasonably assure the safety and protection of the patient and the safety of others.
- G. Staff shall provide the patient with a clear explanation for the reason(s) for using seclusion or restraint, the monitoring procedure, the desired outcome, and the criteria the patient must meet in order for the procedure to be discontinued.
- H. Staff shall implement restraint procedures in a manner to minimize potential medical complications. Staff must be aware of the possibility of patient injury during the application and utilization of restraints.
- I. Sufficient staff shall be present to accomplish placement in seclusion and/or restraint in the safest manner possible.
- J. Staff must consider the potential impact of seclusion or restraints for those patients with a history of trauma such as physical or sexual abuse and be particularly sensitive to the needs of these patients.

- K. Staff shall provide patients in seclusion with constant, uninterrupted in-person observation for the first hour. After the first hour, in-person observation may be replaced by observation using audio and visual equipment in close proximity to the patient. When audio/video observation is used the patient must be observed in-person at least every 15 minutes.
- L. Staff shall provide patients in restraint with constant one-to-one uninterrupted in-person observation.
- M. Direct Care Staff, in close consultation with and direction from the Physician/LIP and Registered Nurse will:
1. Promptly notify the Physician/LIP and/or the RN when a patient exhibits threatening or harmful behavior.
  2. Remove all potentially dangerous items from the patient and the room designated for seclusion/restraint prior to placement in seclusion/restraint.
  3. Apply restraints safely and make adjustments as necessary in order to ensure that the patient is as physically comfortable as possible while restrained. No restraint or body positioning of a patient shall place excessive pressure on the chest or back of the patient or inhibit or impede the patient's ability to breathe. Patients are to be restrained in a manner to minimize potential medical complications.
  4. Provide required level of observation for procedure and as directed by Physician/LIP and RN.
  5. Monitor vital signs at least every two hours or more often as directed. In the event the patient's behavior renders this impossible or unsafe for either the patient or the staff this will be documented in the medical record.
  6. Provide a patient in restraints with an opportunity for range-of-motion exercise for at least 10 minutes at least every two hours, unless the patient's behavior renders this impossible or unsafe for either the patient or the staff or contraindicated by condition of joint or limb.
  7. Change the patient's linen, bedding, and clothing promptly as it becomes soiled.
  8. Offer fluids at least hourly or more frequently if the patient is dehydrated, unless fluids are restricted by a physician's order. Meals and snacks will be offered at regular intervals.
  9. Offer the patient use of toilet facilities or a bedpan/urinal at least hourly and whenever a patient requests a need.

10. Allow and/or assist patients to bathe or shower at least daily when procedures are used for extended periods of time. When necessary, a bed bath may be given. Patients will be provided A.M. and H.S. care including oral care, washing of face, hands, and hair care, and other care and comfort measures as appropriate. Staff will prompt and assist the patient to wash hands before meals and after toileting.
11. Document the following in the patient's medical record according to the Nursing Services Flow Sheet:
  - a. The patient's behavior and physical condition at least every 15 minutes as long as the procedure continues;
  - b. All care offered and care provided to a patient during the procedure including hygiene, diet, fluid intake, bowel/bladder functions, physical observations, range-of-motion, and vital signs
  - c. Any exceptions to care and reason/rational.
  - d. Observations regarding positioning, skin integrity, circulation, and gait.
12. Promptly inform RN about any changes in a patient's behavior or physical condition.
13. Participate in event review process.
14. Complete an incident report whenever the transport blanket is utilized, hands on procedures are utilized, and/or any adverse outcome occurs (falls, injuries, or allegations of abuse) as a result of the procedure. Forward to the Nursing Supervisor for review.

N. Registered Nurses will:

1. Assess the patient and situation to determine imminent dangerousness requiring the emergency use of seclusion or restraint. This assessment will include whether alternatives to the use of seclusion or restraint were adequately attempted or considered.
2. Notify the Physician/LIP of the patient's behavior, alternative approaches used to avoid restraint/seclusion and level of procedure implemented on an emergency basis. Inform Physician/LIP of known pertinent medical health issues. Document this information on the Seclusion/Restraint Order and Progress Note form.
3. Obtain verbal or written order from the Physician/LIP for the procedure prior to implementation or as soon as possible after an emergency implementation of seclusion or restraint and document the order on the Seclusion/Restraint Procedure Order/Progress Note form. The order will include the method of seclusion/restraint to be utilized, clinical rational for use of procedure and behavioral criteria the patient must meet for release/removal from seclusion/restraint.

- AN ORDER TO USE A RESTRAINT OR SECLUSION PROCEDURE IS VALID FOR A MAXIMUM OF FOUR HOURS. IF PROCEDURES ARE CONTINUED, ORDERS MUST BE RENEWED EVERY FOUR (4) HOURS. FACE-TO-FACE EVALUATION OF A PATIENT IN RESTRAINTS OR SECLUSION BY A PHYSICIAN/LIP MUST OCCUR EVERY EIGHT (8) HOURS.
4. Upon the initiation of seclusion/ restraint or as soon as possible after initiation of emergency seclusion/ restraint assess, inform and document on the Seclusion/Restraint Order and Progress Note form the following:
    - a. Current behavioral/mental status
    - b. Current physical status
    - c. Vital signs (at least ever 2 hours)
    - d. Reason for restraint/seclusion explained
    - e. Behavioral criteria for release explained
    - f. Interventions implemented to assist the patient in meeting established release criteria and the patient's response
  5. Assess the patient in seclusion/restraint at least every hour (one (1) hour intervals), and document on the Seclusion/ Restraint Order and Progress Note utilizing the format as noted above.
  6. Supervise and assist staff in the safe implementation of seclusion and restraint procedures.
  7. Obtain additional physician's orders should an increased level of intervention become necessary (e.g., any modification that increases the level of restraint, change in the placement of the patient from seclusion to restraint).
  8. Direct the reduction of the level of restraint and the termination of the procedure when the criteria for release as set by the Physician/LIP is met and the patient is no longer an imminent danger to self or others.
  9. Direct, delegate and ensure proper care and level of observation, along with accurate documentation and reporting of the procedure.
  10. The Nurse Manager and/or staff RN will review the event with all involved staff as soon as possible following the procedure to determine patient management strategies to avoid future incidents. The review will be documented on the Event Review Form.

F. Psychiatrists/Licensed Independent Practitioners (LIP):

1. Will give orders authorizing the use of seclusion and restraint procedures (including any modifications). The initial order is valid for four (4) hours. Orders must be renewed every four (4) hours as long as the restraint or seclusion procedure continues.
2. Must conduct a face-to-face evaluation of the patient within one (1) hour of the time a seclusion or restraint procedure is initiated, and document the reason the procedure is required and actions to be taken to provide for the patient's care and treatment needs. The face-to-face evaluation within the hour is required even if the procedure is discontinued in less than one (1) hour.
3. Are required to authorize the continuation of seclusion or restraint procedures at four (4) hour intervals. **FACE-TO-FACE EVALUATION OF A PATIENT IN RESTRAINTS OR SECLUSION BY A PHYSICIAN/LIP MUST OCCUR EVERY EIGHT (8) HOURS** for as long as the procedure continues. In the event of exceptional circumstances requiring the use of a prolonged restraint or seclusion intervention, the frequency for conducting face-to-face evaluations by a physician/LIP may be modified upon written authorization of the Medical Director or Hospital Administrator. Any modification must conform to state and federal requirements.
4. Provide orders that clearly state:
  - a. reason or justification for the procedure,
  - b. specific type of procedure to be used
  - c. maximum time period allowed for the procedure,
  - d. criteria for release,
  - e. date and time.
5. Participate in the event review process as indicated.
6. Document on the Seclusion and Restraint Intervention Order/Progress Note each time a face-to-face assessment is completed. Documentation will include:
  - a. behavior leading to procedure;
  - b. rationale for use of procedure;
  - c. current behavioral/mental status;
  - d. current physical status
  - e. plan for continuing care

G. Team Leaders will:

1. Conduct and complete required Event Review process with patient and staff.

2. Ensure the Event Review conducted with staff only is filed for future reference and the Event Review conducted with the patient is filed in the Medical Record under the Treatment Plan.
3. Ensure the review and revision of the patient's treatment plan as indicated.
4. Inform the Hospital Administrator of all procedures that last more than 24 hours.

- H. The Quality Improvement Director will be responsible for tracking use of these procedures throughout the hospital and disseminating data about use of restraint and seclusion to all staff members.
- I. Hospital Administrator is responsible for promoting activities that protect patient and staff safety and lead to a reduction in the use of seclusion and restraint procedures. This will be done through analysis of incidents that do occur and utilizing information to improve staff skills and patient treatment. This will also be done by promoting therapeutic non-coercive approaches to treatment and providing trauma informed care that recognize the use of restraints and seclusion as having the potential to further traumatize both patients and staff.

**V. PROCEDURE:**

A. Seclusion/Restraint Procedure:

1. Staff respond immediately to emergency behavioral crisis, taking needed action to keep the patient and others safe.
2. Seclusion or restraint will be utilized if necessary, in accordance with staff responsibilities outlined in section IV.

B. Procedure for Termination of Seclusion/Restraint:

1. RN has assessed that the patient no longer requires seclusion or restraint; or
2. Physician/LIP has assessed and ordered the discontinuation of seclusion or restraint; or
3. Any staff member determines that the patient's health, safety, or welfare requires immediate release.

C. Documentation Procedure:

1. All staff will document in accordance with role and responsibility.

D. Reporting Procedures:

1. An incident report will be completed whenever the transport blanket is utilized, hands on restraint procedures are utilized, and/or any adverse outcome occurs

(falls, injuries, or allegations of abuse). The RN will forward the incident report to the Safety Officer.

2. The Nurse Manager and or Team Leader will ensure that a copy of every Seclusion and Restraint Intervention Order/Progress Note is forwarded to the Quality Improvement Director.
3. The Quality Improvement Director will ensure a process to maintain a database, prepare and distribute reports regarding these occurrences at periodic intervals but not less than monthly. This information is analyzed and reported on a quarterly basis to the Hospital Administrator, Quality Improvement Committee, Medical Director, Director of Nursing Services, and to the medical staff.
4. In the event of a significant, adverse outcome from seclusion/restraint, the Hospital Administrator will notify appropriate outside agencies (CMS, state licensure, and law enforcement.)

**E. Training procedures:**

1. Staff will be educated and their competency tested regarding Use of Seclusion and Restraint Policy and procedure during initial orientation and annually thereafter by the Staff Development Department. Additional training will be provided when needs are identified.
2. Patients, and when appropriate, families will be educated regarding seclusion/restraint use.

**F. Equipment Maintenance**

1. Assigned nursing personnel will examine all restraint devices upon each application and no less than monthly to ensure devices are working properly, are clean, and are in good repair. Documentation of the monthly review will be included on a chart that is to be kept on each treatment unit where devices are stored.

**VI. REFERENCES:** Standards/Statutes: 53-21-146 M.C.A.; M.C.A. 53-21-147 Patient Rights; CMS 42 CFR Part 482 conditions of participation for hospitals, Subpart B – 482.13 Patient Rights and, (f) Seclusion and Restraint for behavior management.

**VI. COLLABORATED WITH:** Seclusion and Restraint Committee Chair, Director of Nursing Services, Medical Director, and Hospital Administrator.

**VIII. RESCISSIONS:** #TX-16, *Use of Seclusion and Restraint* dated March 20, 2006; #TX-16, *Use of Seclusion and Restraint* dated November 17, 2004; #TX-16, *Use of Seclusion and Restraint* dated June 18, 2001; HOPP #13-03R.070073 -- *Use of Behavior Control, Seclusion, and Restraint* dated 1/31/96.

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| _____<br>Ed Amberg<br>Hospital Administrator | ____/____/____<br>Date | _____<br>Thomas Gray, MD<br>Medical Director | ____/____/____<br>Date |
|--|------------------------|--|------------------------|

## LIST OF APPROVED RESTRAINTS

1. Physical Technique – Body holds that temporarily restrict a patient's freedom of movement if these are used as a stand-alone treatment intervention. All documentation and care procedures will be completed in the same manner used for other restraints. Behavioral Crisis responses to ensure safety which are not a treatment intervention, but are used as a brief reactive response to a crisis, and follow MANDT physical management training are not restraints. Restrictions of a patient's movement, which are preparatory to the initiation of seclusion and restraint, are authorized and documented as part of the seclusion and restraint process.
2. Emergency Transport Restraints – Wrist and ankle restraints, or the transport blanket may be used for brief periods to safely transport a patient exhibiting behaviors of imminent dangerousness. Examples of this use include use of wrist and/or ankle restraints to transport a patient on unauthorized leave safely back to their treatment unit, or use of the transport blanket to transport an acting-out patient to a safe location within a treatment unit. Use of emergency transport restraints require an order and face-to-face evaluation by a physician/LIP within one hour, and with documentation and review required just as with all other use of restraint procedures.
3. Chair Restraint - Patients may be restrained to an appropriate chair designed for this purpose when a physician/LIP orders such an intervention. Restraints including belts, cuffs, soft ties, anklets, posey belts, and cloth vests may be used.

All restraints must be secured to the frame of the chair with buckles either padded or located away from the patient's body. Chair restraints may include waist only, waist/wrist, or full as specified in the physician's order. Chair restraint is allowed only if the patient is provided appropriate privacy throughout the duration of the intervention.

4. Bed Restraint - Belts, nylon webbed belts, cuffs, soft ties, or combinations of soft ties may be used to restrain patients to a bed when necessary for the patient's self-protection, or the protection of anyone who may have to enter a seclusion room to render care to the patient.

The level of restraint used may vary according to physician/LIP order and clinical judgment. At a minimum, the patient is to be restrained at the waist and one ankle. Additional limbs (other ankle and wrists) may also be restrained if necessary.

All restraints will be securely fastened to the frame of the bed. All buckles and other protrusions from restraint devices will be padded or located so that they do not rub against the patient's body. Any time that any form of bed restraint is used for behavioral interventions, the room must be locked when a staff member is not present in order to prevent the entry of unauthorized persons.

The term FULL RESTRAINTS refers to the placement of a patient on a bed with restraints applied to the waist, each ankle, and each wrist. Any modification increasing the level of full restraints necessary to ensure patient safety requires a physician/LIP order describing the type, placement of restraint, and justification for the modification.

The term WAIST AND ANKLE RESTRAINTS refers to the placement of a patient on a bed with restraints applied to the waist and one or both ankles.

6. Waist/Wrist Ambulatory Restraints -- Patients may be placed in waist/wrists ambulatory restraints.

7. Other Types of Restraint

Occasionally it is necessary to use other restraint procedures (e.g., placing a person's hands in mittens to reduce the risk of self-injury). In such a case, a physician/LIP order is obtained in advance and must specifically designate the type of restraint to be used.

A progress note will be written by the physician/LIP providing the rationale for the action taken. All documentation and care procedures will be completed in the same manner used for other restraint procedures.

8. Prohibited Restraint Devices - *Handcuffs or other law enforcement types of restraint devices are prohibited.*

**MONTANA STATE HOSPITAL**  
**SECLUSION/RESTRAINT ORDER and PROGRESS NOTE**

**Patient Name:** \_\_\_\_\_ **MSH #:** \_\_\_\_\_ **Unit:** \_\_\_\_\_ **Page #:** \_\_\_\_\_

Antecedents/Behavior leading to procedure: \_\_\_\_\_

Describe Methods Used to Avoid Restraint and Seclusion; i.e. verbal reassurances/redirection, 1:1 interaction, stimuli reduction, diversional activities, ventilation of feelings, environmental change, medication: \_\_\_\_\_

**Medical Concerns:**    ☐ Obesity        ☐ Spinal Injury    ☐ Pregnancy    ☐ Recent Emesis        ☐ Hx of Seizures  
☐ Diabetes        ☐ Cardiac        ☐ Respiratory (URI, asthma)    ☐ Recent food/fluid intake    ☐ Hx of Trauma  
☐ Compromised skin integrity        ☐ Severe exertion associated with procedure        ☐ No injury Noted  
☐ Injury at time of procedure (describe): \_\_\_\_\_  
☐ Others: \_\_\_\_\_

**PHYSICIAN/LIP ORDER (Valid up to 4 hours)**

**RATIONALE FOR SECLUSION AND/OR RESTRAINT**

**Initiated: Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **Original Order Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

☐ Imminent Danger to Self        ☐ Imminent Danger to others        ☐ Other (explain): \_\_\_\_\_

Explanation: \_\_\_\_\_

**Patient to be placed in:**    ☐ Seclusion    ☐ Full Bed Restraints    ☐ Full Chair Restraints    ☐ Transport Blanket Used  
☐ Other (Explain): \_\_\_\_\_

**RELEASE CRITERIA (as specified by Physician/LIP):** \_\_\_\_\_

**VO/PO RN:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Physician/LIP Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**RN ASSESSMENT (Initial)**

Current behavioral/mental status: \_\_\_\_\_

Current physical status: \_\_\_\_\_

Vital signs: \_\_\_\_\_

Following explained to patient:    ☐ Reason for R/S        ☐ Behavioral criteria for release

Interventions implemented to assist in meeting release criteria and response: \_\_\_\_\_

**Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **RN Signature:** \_\_\_\_\_

**PHYSICIAN/LIP ASSESSMENT**

Behavior leading to procedure: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Rationale for use of procedure: \_\_\_\_\_  
\_\_\_\_\_

Current behavioral/mental status: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current physical status: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Plan: \_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Physician/LIP Signature: \_\_\_\_\_

**RN ASSESSMENT (Required at least every hour)**

Current behavioral/mental status: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current physical status: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Vital signs (at least every 2 hours): \_\_\_\_\_

Current behavior justifying procedure: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Following explained to patient: ☐ Reason for R/S ☐ Behavioral criteria for release  
Intervention implemented to assist in meeting release criteria and response: \_\_\_\_\_  
\_\_\_\_\_

**Current level of procedure:** ☐ Seclusion ☐ Full Bed Restraints ☐ Full Chair Restraints  
☐ Waist, Ankle ( L , R ) and Wrist ( L , R ) ☐ Other: \_\_\_\_\_  
☐ Discontinue Seclusion ☐ Discontinue Restraints

Date: \_\_\_\_\_ Time: \_\_\_\_\_ RN Signature: \_\_\_\_\_

## SECLUSION/RESTRAINT ORDER and PROGRESS NOTE

**RN ASSESSMENT (Required at least every hour)**

Page #: \_\_\_\_\_

Current behavioral/mental status: \_\_\_\_\_

\_\_\_\_\_

Current physical status: \_\_\_\_\_

\_\_\_\_\_

Vital signs (at least every 2 hours): \_\_\_\_\_

Current behavior justifying procedure: \_\_\_\_\_

\_\_\_\_\_

Following explained to patient: ☐ Reason for R/S ☐ Behavioral criteria for release

Intervention implemented to assist in meeting release criteria and response: \_\_\_\_\_

\_\_\_\_\_

**Current level of procedure:** ☐ Seclusion ☐ Full Bed Restraints ☐ Full Chair Restraints

☐ Waist, Ankle ( L , R ) and Wrist ( L , R ) ☐ Other: \_\_\_\_\_

☐ Discontinue Seclusion ☐ Discontinue Restraints

**Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **RN Signature:** \_\_\_\_\_

**RN ASSESSMENT (Required at least every hour)**

Current behavioral/mental status: \_\_\_\_\_

\_\_\_\_\_

Current physical status: \_\_\_\_\_

\_\_\_\_\_

Vital signs (at least every 2 hours): \_\_\_\_\_

Current behavior justifying procedure: \_\_\_\_\_

\_\_\_\_\_

Following explained to patient: ☐ Reason for R/S ☐ Behavioral criteria for release

Intervention implemented to assist in meeting release criteria and response: \_\_\_\_\_

\_\_\_\_\_

**Current level of procedure:** ☐ Seclusion ☐ Full Bed Restraints ☐ Full Chair Restraints

☐ Waist, Ankle ( L , R ) and Wrist ( L , R ) ☐ Other: \_\_\_\_\_

☐ Discontinue Seclusion ☐ Discontinue Restraints

**Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **RN Signature:** \_\_\_\_\_

**RN ASSESSMENT (Required at least every hour)**

Current behavioral/mental status: \_\_\_\_\_

\_\_\_\_\_

Current physical status: \_\_\_\_\_

\_\_\_\_\_

Vital signs (at least every 2 hours): \_\_\_\_\_

Current behavior justifying procedure: \_\_\_\_\_

Following explained to patient: ☐ Reason for R/S ☐ Behavioral criteria for release

Intervention implemented to assist in meeting release criteria and response: \_\_\_\_\_

\_\_\_\_\_

**Current level of procedure:** ☐ Seclusion ☐ Full Bed Restraints ☐ Full Chair Restraints☐ Waist, Ankle (L, R) and Wrist (L, R) ☐ Other: \_\_\_\_\_☐ Discontinue Seclusion ☐ Discontinue Restraints**PHYSICIAN/LIP CONTINUATION ORDER***(Valid up to 4 hours, then requires Physician/LIP face to face evaluation and new order)***Rationale:** ☐ Imminent Danger to Self ☐ Imminent Danger to Others☐ Other (explain): \_\_\_\_\_

Release Criteria: \_\_\_\_\_

\_\_\_\_\_

**VO/PORN:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_**Physician/LIP Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_**RN ASSESSMENT (Required at least every hour)**

Current behavioral/mental status: \_\_\_\_\_

\_\_\_\_\_

Current physical status: \_\_\_\_\_

\_\_\_\_\_

Vital signs (at least every 2 hours): \_\_\_\_\_

Current behavior justifying procedure: \_\_\_\_\_

\_\_\_\_\_

Following explained to patient: ☐ Reason for R/S ☐ Behavioral criteria for release

Intervention implemented to assist in meeting release criteria and response: \_\_\_\_\_

\_\_\_\_\_

**Current level of procedure:** ☐ Seclusion ☐ Full Bed Restraints ☐ Full Chair Restraints☐ Waist, Ankle (L, R) and Wrist (L, R) ☐ Other: \_\_\_\_\_☐ Discontinue Seclusion ☐ Discontinue Restraints**Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **RN Signature:** \_\_\_\_\_

## LESS RESTRICTIVE MEASURES TO SECLUSION OR RESTRAINT INTERVENTIONS TAUGHT IN MANDT TRAINING

- \* The main goal of the Mandt System is to teach (staff) how to effectively manage a potentially negative or even dangerous situation by first calming your emotional response and managing your own behavior so you can interact with other people positively.
- \* The program presents a system of gradual and graded alternatives for deescalating and managing people, using interpersonal skills.
- \* Options include:
  - Allow the patient to feel all his/her feelings
  - staff's actions need to be motivated by need to protect and teach,
  - identifying anger as an emotion/anger is okay, and
  - understanding fear as an instinct/fear is okay
- \* Crisis cycle – 6 phases – 6 responses
  - Response 1: *Removal of or From Stimuli* – Stay calm, search for the person's trigger mechanisms, and be an active and not a judgmental listener.
  - Response 2: *Offer Appropriate Options* – Avoid either/or choices, communicate understanding, allow the person to exercise his/her personal freedom and rights, use diversion and/or distraction, channel feelings into a positive direction or creative activity such as music.
  - Response 3: *Least Amount of Interaction Necessary* – Stay calm, don't overreact, careful about tone of voice and choice of words.
  - Response 4: *Structured Cooling Off* – Removal of or from stimulus e.g. time out, go for a walk, time alone in quiet day hall, avoid either/or choices, diversion and/or distraction, humor, food, one to one, read a book, or write in a journal.
  - Response 5: *Active Listening* – Use good nonverbal and verbal skills, give reassurance, find out what problem is, communicate with team (more options).
  - Response 6: *Observation and Support* – Rest and quiet time, give reassurance, help person to understand feelings, allow person to save face, and maintain dignity.